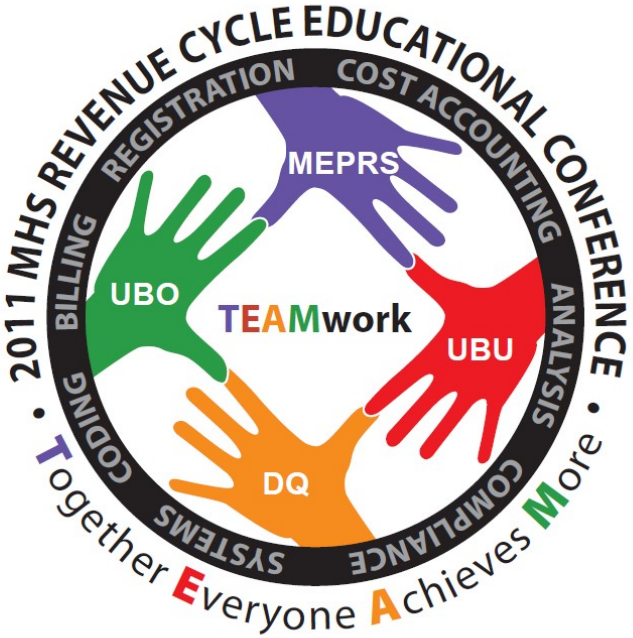


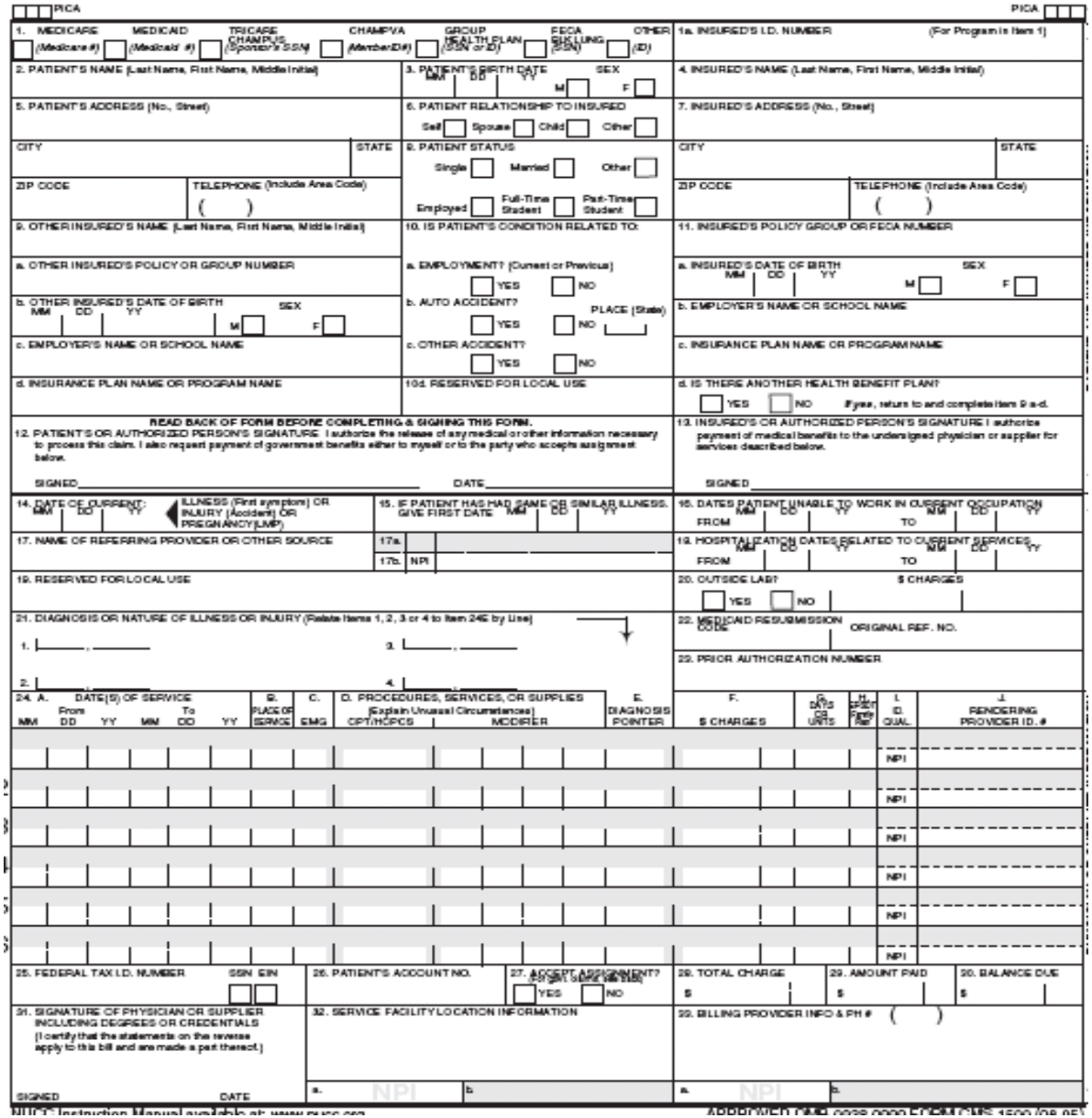
Title: **Basic UBO Billing – CMS 1500**

Session: **T-1-1330**

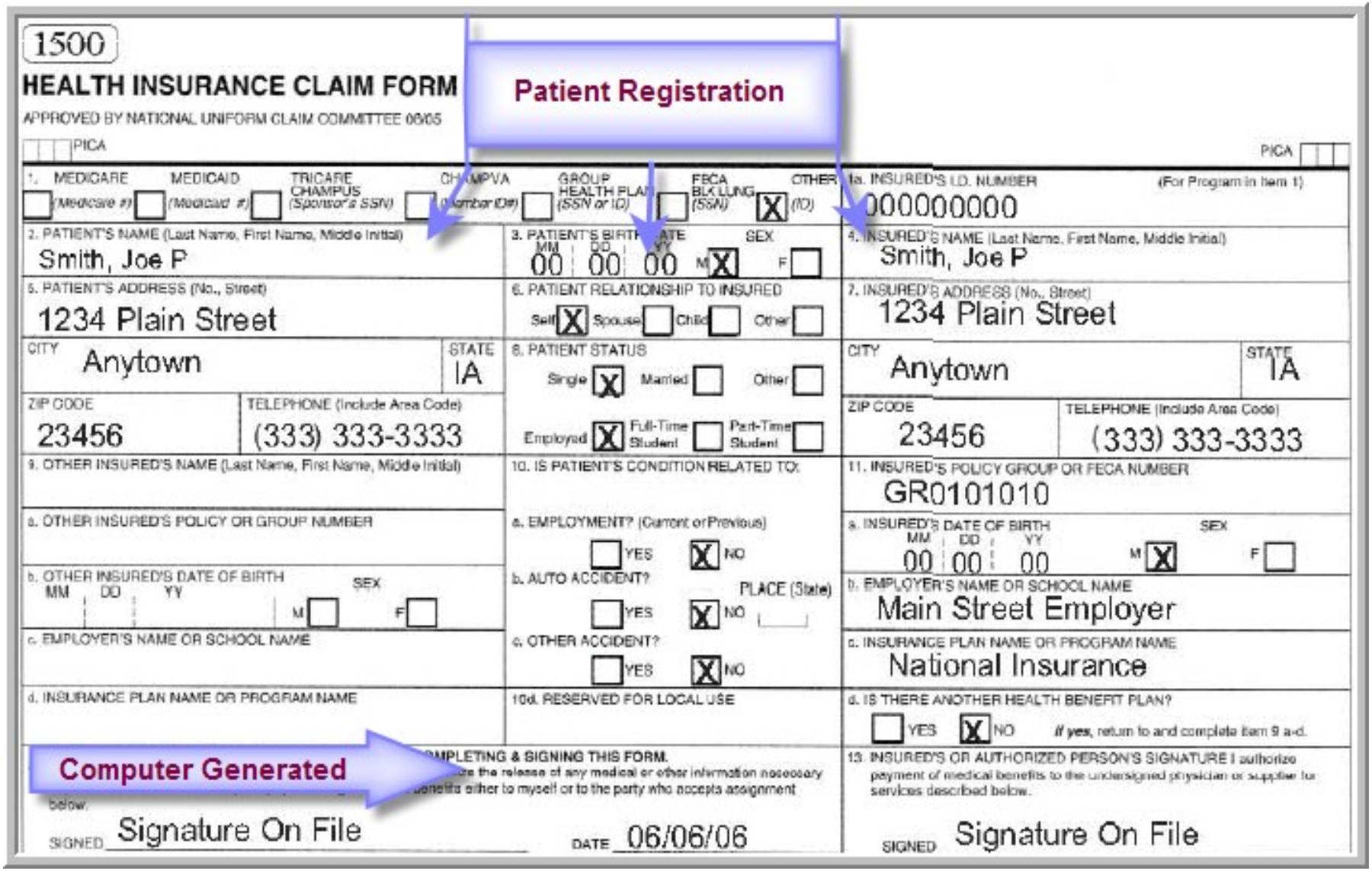
Objectives

- Understand the data elements necessary for claim submission
- Know which data elements are required and which are situational
- Understand how elements link together to give the total picture of what happened during the patient encounter

1500 Claim Form



1500 Claim Form



1500 Claim Form

Items are automatically populated by TPOCS

Item 1: Required
Type of Health Insurance Coverage
Insurance coverage. System defaults to “Other”

Item 1a: Required
Insured’s ID Number
Insured’s social security number

Item 2: Required
Patient’s Name (Last Name, First Name, Middle Initial)
Patient’s last name, first name, and middle initial

Item 3: Required
Patient Birth date
Eight-digit birth date (MM|DD|CCYY) of the patient

1500 Claim Form

Item 3: Required
Patient's Sex
Patient's sex

Item 4: Required
Insured's Name (Last Name, First Name, Middle Initial)
Insured's last name, first name, and middle initial

Item 5: Required
Patient's Address
Mailing address and telephone number of the patient in the corresponding boxes

1500 Claim Form

Item 6: Required
Patient's Relationship to Insured
Relationship of the patient listed in Item 2 to insured listed in Item 4

Item 7: Required, if applicable
Insured's Address
Mailing address and telephone number of the insured in the corresponding box. If Item 4 is completed, then this field should be completed

Item 8: Required
Patient Status
Marital status and full- or part-time student.
NOTE: Patient Status does not exist in the electronic 837 Professional 41010A1

1500 Claim Form

Item 9: Required, if applicable
Other Insured's Name
If the 'Yes' is checked in Item 11D,
then this section (Items 9–9D) must be filled out.
Name of the insured person (last, first, middle initial)

Item 9a: Required, if applicable
Other Insured's Policy or Group Number
Other insured's insurance policy or group number

1500 Claim Form

Item 9b: Required, if applicable
Other Insured's Date of Birth/Sex
Eight-digit date of birth (MM|DD|CCYY). Check the appropriate box
indicating the sex of this person

Item 9c: Required, if applicable
Employer's Name or School Name
Employer's name or school name of the other insured person.
NOTE: Employer's Name or School Name do not exist in the electronic 837 Professional 41010A1

Item 9d: Required, if applicable
Insurance Plan Name or Program Name
Name of the insurance plan or program related to the other insured person

1500 Claim Form

Item 10a-10c: Required, if applicable
Is Patient's Condition Related To: (Auto Accident/Other Accident)
Check the appropriate box if the patient's condition is related to any
of the following: employment (MAC), auto accident, or other accident

Item 10d: Not Required
Reserved For Local Use
Leave blank

Item 11: Conditional
Insured's Policy Group or FECA Number
Insured's policy group or FECA number

Item 11a: Required
Insured's Date of Birth/Sex
Eight-digit date of birth (MM|DD|CCYY); check the appropriate box indicating the sex of the insured

1500 Claim Form

Item 11b: Conditional
Employer's Name or School Name
Employer's name or school name of the insured.
NOTE: Employer's Name or School Name do not exist in the electronic 837 Professional 41010A1

Item 11c: Required
Insurance Plan Name or Program Name
Name of the insurance plan or program of the insured

Item 11d: Required, if applicable
Is There Another Health Plan Benefit?
If 'Yes' is checked, Items 9–9d must be completed.
Check the appropriate box to indicate whether or not there is another health insurance benefit. System defaults to "No"

1500 Claim Form

Item 12: Required with a default ("Signature on file" is acceptable)
Patient's or Authorized Persons Signature
This item is automatically populated with the following statement,
"Assignment of Benefits is assumed under 10 U.S.C. 1095"

Item 13: Required with a default ("Signature on file" is acceptable)
Insured's Authorized Person's Signature
This item is automatically populated with the following statement,
"Assignment of Benefits is assumed under Title 10 U.S.C. 1095" and
with "Signature on file"

Item 14: Required, if applicable
Date of Current Illness, Injury, or Pregnancy
Current date of illness, injury or pregnancy (MM|DD|CCYY)

1500 Claim Form

Item 15: Required, if applicable
If Patient Has Had Same or Similar Illness
Past occurrence date (MM|DD|CCYY) of illness or injury
if it is the same or similar illness or injury

Item 16: Not Required
Dates Patient Unable to Work in Current Occupation
Leave blank

Item 17: Conditional (Revised- Title was changed from Referring Physician to Referring Provider)
Name of Referring Provider or Other Source
Name of the provider who referred or ordered the service

1500 Claim Form

Item 17a: Conditional (Revised–This area was shaded and a
new field was added to hold the two-digit qualifier for other ID Number)
The Other ID Number of Referring or Ordering Provider, Qualifier
The Provider Taxonomy code of the referring provider or ordering
provider should be reported in the shaded area. The qualifier (**PX- Provider Taxonomy)** identifies the type of Other ID being reported in the shaded area

Item 17b: Required, if applicable
Provider NPI #
NPI Type1 of the referring or ordering provider will appear in this field, if available. If NPI is missing, then the Current Provider ID and/or Tax ID will be reported in Item 17a until the NPI is provided

Item 18: Required, if applicable

1500 Claim Form

Item Number 17, 17a, and 17b (split field)

17: Name of Referring Provider or Other Service
TPOCS will populate the referring provider information in Items 17, 17a and/or 17b

17a: Other ID#
Current Provider ID and/or Tax ID will be used until the NPI # is used.
Once NPI is implemented, the primary HIPAA taxonomy code associated
with the provider specialty table will be reported for the referring provider,
ordering or other source and will populate from TPOCS

17b: NPI
The NPI number of the referring provider will populate from TPOCS

1500 Claim Form

Item 19: Not Required
Reserved for Local Use
Leave blank

Item 20: Not Required
Outside Lab
Leave blank

Item 21: Required
Diagnosis or Nature of Illness or Injury
ICD-9-CM diagnosis code for the patient's diagnosis/condition. The ICD-9-CM diagnosis code must be coded to the highest specificity and sequenced in order of priority (e.g., primary or secondary condition)

Item 22: Not Required
Medicaid Resubmission
Leave blank

1500 Claim Form

Item 23: Required, if applicable

Prior Authorization Number

Prior authorization number for those procedures requiring prior authorization

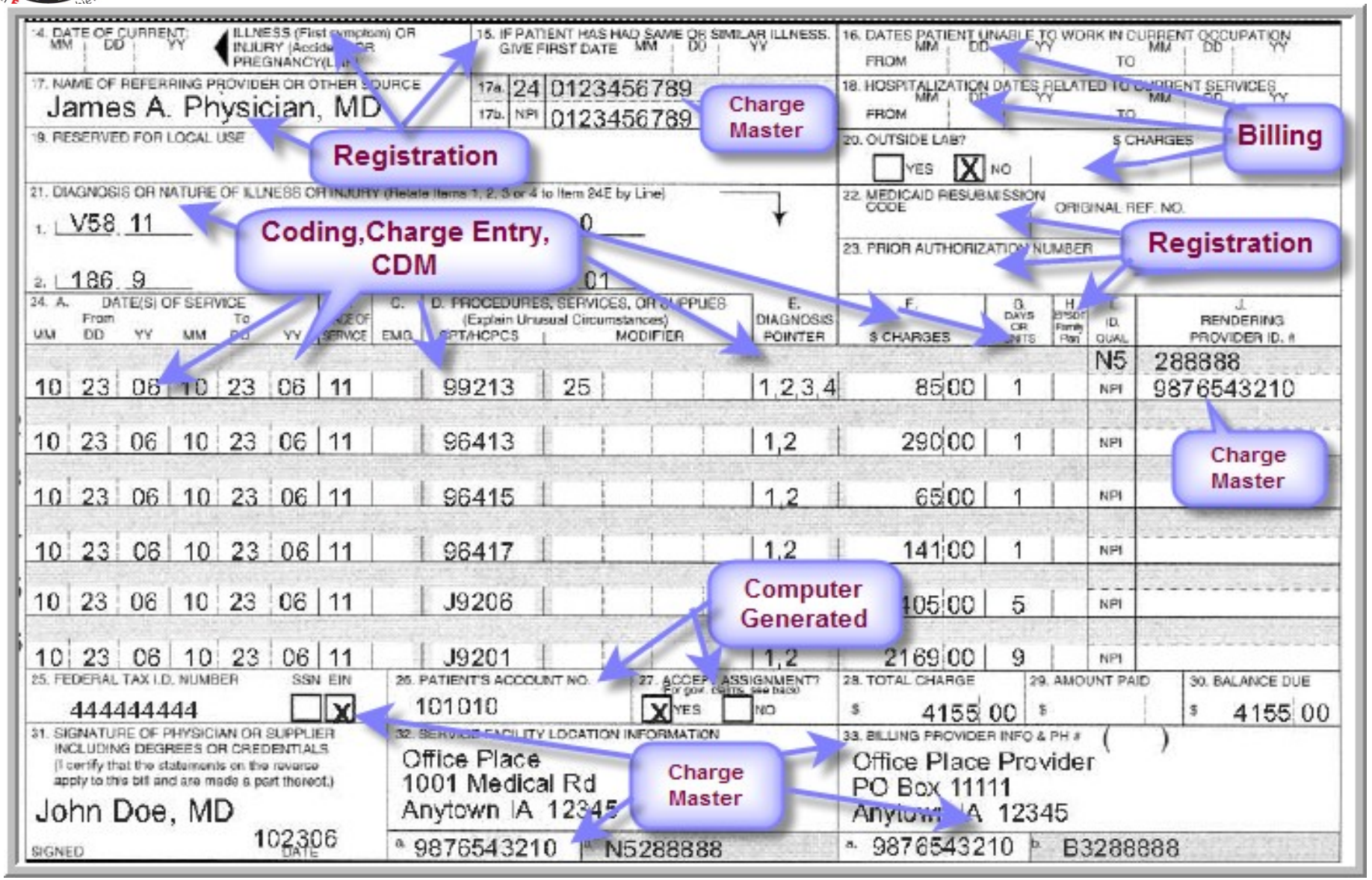
Section 24 (Revised—To accommodate submission of both the NPI and other Provider Identifier during the NPI transition)

Item 24a: Required

Dates of Service

Eight-digit date (MM|DD|CCYY) of the time period in which the services were performed

1500 Claim Form



1500 Claim Form

Item 24b: Required
Place of Service
Code “26” represents an MTF. This code should automatically print on all CMS-1500s. However for an emergency room visit, the place of service will be coded as "23" Emergency Room. TPOCS will provide the biller the option to determine if the encounter is related to ER services. When saving the bill TPOCS will assign the place of service based on MEPRS code BIA* and default to "Y" (yes) for Item 24c -EMG

Item 24c: Required, if applicable (Revised–This was originally titled "Type of Service." This field is now titled "EMG“)
EMG
EMG represents Emergency Indicator. The indicator states whether or not a service(s) is related to an emergency. If MEPRS code is BIA* and services are emergency related, then Y for "Yes" will appear in the box or if "No" the field will be left blank

1500 Claim Form

Item 24d: Required
Procedures, Services, or Supplies
HCPCS/CPT code, including modifiers when applicable, for the
procedures, services, or supplies furnished to the patient

Item 24e: Required (Revised–Title changed from Diagnosis Code to Diagnosis Pointer)
Diagnosis Pointer
Pointer number (1–4) from Item 21 that is applicable to that specific procedure, service, or supply furnished

Item 24f: Required
Charges
Charge for each listed service.

1500 Claim Form

Item 24g: Required
Days or Units
Number of days or units that were supplied for that particular HCPCS/CPT code listed in that line. If only one service was provided, the numeral 1 must be entered. This field will default to 1

Item 24h: Not Required
EPSDT Family Plan
Leave blank

Item 24i: Required (Revised–This field was originally titled "EMG,"
which is now in Item 24c. This field is now titled "ID Qualifier")
ID Qualifier
The ID qualifier will default to (**PX- Provider Taxonomy)** and will be used to report the type of non-NPI number of the rendering provider. The Provider Taxonomy code of the rendering provider will be reported in the shaded area of Item

1500 Claim Form

Item 24j: Required (Revised–This field was originally title "COB."
The original fields 24j and 24k were combined and renumbered and
now titled "Rendering Provider ID#”)
Rendering Provider ID#
The Provider Taxonomy code of the rendering provider will be reported in
the shaded area. NPI Type 1 of the rendering provider will be reported in the unshaded area.

Item 24k: This field was deleted and combined with 24j.
Deleted

Item 25: Required
Federal Tax ID Number

1500 Claim Form

Item 26: Required
Patient's Account Number
Patient's account number that is assigned by the MTF's accounting system to identify that particular patient

Item 27: Required
Accept Assignment
TPOCS defaults to "X" in the 'Yes' box, indicating assignment of benefits is accepted pursuant to Title 10 U.S.C. 1095

Item 28: Required
Total Charge
Total charges for the services provided (e.g., sum of charges in Item 24F)

Item 29: Conditional
Amount Paid
$0.00 indicates no up-front monies were paid. DoD does not collect
co-payments for services rendered

1500 Claim Form

Item 30: Conditional
Balance Due
Total amount of the charges. This should match Item 28

Item 31: Required
Signature of Physician or Supplier
Signature of the provider of service or supplier, or his representative, and the date the form was signed. A signature or stamp is required here. Some MTFs use this area to indicate who, the biller was and that the bill has been reviewed

Item 32: Required-Treating Service Facility
Name and Address of Facility Where Services Were Rendered
Name, address, and telephone number of the MTF

Item 32a: Required (New field)
NPI #
NPI Type 2 of the treating MTF will be reported in this field

1500 Claim Form

Item 32b: Required (New field)
Other ID Qualifier and Other ID#
The qualifier will be reported followed by the HIPAA Taxonomy code or Treating Facility Tax ID

Item 33: Required- Billing Provider Information
Physician, Supplier Billing Name, Address, Zip Code, Phone, PIN#, and Group#
Name of the physician who rendered the services. It is now required that the provider be identified with their credentials (e.g., MD, NP, PA, RN, LPN). The system should include the provider's credentials following the name

1500 Claim Form

Item 33a: Required (New field)
NPI #
NPI Type 2 of the billing facility will be reported

Item 33b: Required (New field)
Other ID#
The qualifier followed by the HIPAA Taxonomy or Billing Facility Tax ID will be reported

Summary

1. We have reviewed the data elements necessary for claims submission
2. We know why these are required
3. And which ones are required on the form or are situational

Questions

- Thank you for attending this session and learning about how to fill out the professional CMS 1500 claim form
- Any questions?